



State of Georgia Flexible Benefits Program  
Leave Without Pay (LWOP)  
Benefit Continuation Form

**Instructions:** Review the following information and indicate in the box below if you do or do not want to continue your benefit coverage. Return your signed form to your department along with your check, if applicable, to the department address shown below.

**Indicate Type of Leave Without Pay:**

- ☐ Regular Leave (LWOP – Leave Without Pay)  
☐ Family Leave (FMLA - Family Medical Leave Act)  
☐ Military leave (USERRA – Uniformed Services Employment Reemployment Rights Act)

Employee's Name \_\_\_\_\_ Employee's SSN \_\_\_\_\_  
Employee's Home Address \_\_\_\_\_  
Employee's Home Phone # \_\_\_\_\_  
Employee's Last Day Physically at Work \_\_\_\_\_  
Last Payroll Deduction Date \_\_\_\_\_  
Leave Begin Date \_\_\_\_\_ End Date \_\_\_\_\_  
Expected Return to Work Date \_\_\_\_\_

Department Name \_\_\_\_\_  
Department Address \_\_\_\_\_  
Department Contact Name & Phone # \_\_\_\_\_

**Coverage Options and Premiums:**

Life \$ \_\_\_\_\_ Dependent Life \$ \_\_\_\_\_ HCSA \$ \_\_\_\_\_ DCSA \$ \_\_\_\_\_ \*  
Spouse Life \$ \_\_\_\_\_ AD&D \$ \_\_\_\_\_ LTD \$ \_\_\_\_\_ \*\* STD \$ \_\_\_\_\_ \*\*  
Vision \$ \_\_\_\_\_ Legal \$ \_\_\_\_\_ Dental \$ \_\_\_\_\_ LTC \$ \_\_\_\_\_  
Specified Illness \$ \_\_\_\_\_ Spouse Specified Illness \$ \_\_\_\_\_ HSA \$ \_\_\_\_\_

**Total Monthly Premium Amount Due:** \$ \_\_\_\_\_

*\*While on Military Leave, an employee may continue their Dependent Care Spending Account (DCSA). Contributions are not allowed to the DCSA for those employees on LWOP or FMLA. The IRS Regulations specify the employee and spouse must be working full time to contribute towards the DCSA.  
\*\*Waiver of Premium may apply. Review Summary Plan Description for details.*

**PLEASE INDICATE A SELECTION BELOW AND SIGN**

- ☐ I have read the Leave Information Sheet and want to continue my benefit coverage through the Pre-Pay Option. I understand my rights and responsibilities for making payments to continue my benefit coverage.
- ☐ I have read the Leave Information Sheet and want to continue my benefit coverage through the Pay-As-You-Go Option. I understand my rights and responsibilities for making payments to continue my benefit coverage.
- ☐ I have read the Leave Information Sheet and do not want to continue my coverage. I understand by not choosing a method of direct personal premium payments, my coverage will terminate the end of the month following my last payroll deduction.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date